STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085004	A. BUILDING _____ B. WING _____	C 07/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE NURSING & REHABILITATION CENTER	505 GREENBANK ROAD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility from July 10, 2018 through July 19, 2018. The deficiencies contained in this report are based on interviews, record reviews, and review of other documentation as indicated. The survey sample included three (3) closed records. Abbreviations/definitions used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; UM - Unit Manager; RN - Registered Nurse; NP- Nurse Practitioner; SS - Social Services; ED- Executive Director; %-percent; > greater than; @- at; Acute Renal Failure- the kidneys suddenly become unable to filter waste products from your blood which can be fatal/deadly; Agency Nurse- a nurse provided by a contracted nursing agency; Assessment- evaluation; Blood Pressure (BP)- normal range is less than 120/80; BLS-basic life support; Cellulitis- a bacterial infection underneath the skin characterized by redness, warmth, swelling, and pain; Dementia- a chronic or persistent disorder of the mental processes marked by memory impairment, personality changes, and impaired reasoning that interfere with daily life;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/14/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1	F 000		

DOE- dyspnea on exertion; difficulty breathing when moving around;
Etc.(etcetera)- used at the end of list to indicate that further, similar items are included;
EMS-emergency medical services;
ER-emergency room;
Hypoxic/hypoxia- a deficiency of oxygen reaching the tissues of the body;
ICU-intensive care unit;
L/min.- liters per minute;
LTC- long term care;
Med-medication;
Nasal cannula- a lightweight tube with 2 prongs that are placed in the nostrils to deliver supplemental oxygen;
O2- oxygen;
Oxygen concentrator- a medical device used to deliver oxygen by filtering in air, compressing it and delivering it continuously; it does not run out like an oxygen tank does;
PT-patient;
Pneumonia (PNA)- lung inflammation caused by bacterial or viral infection;
Pulse-P- heart rate; normal range 60-100 beats per minute;
Pulse oximetry (pulse ox)- a non-invasive test used to measure oxygen levels in the blood; normal range 95-100%;
Respirations- normal range 12-20 breaths per minute;
SOB- shortness of breath;
STAT- immediately;
Temperature- normal range 97.0- 99.0 degrees;
Via- by;
Vital signs- clinical measurements, specifically pulse rate, temperature (T), respiration rate (R), and blood pressure that indicate the state of a patient's essential body functions;
UTI (urinary tract infection) - bacteria in urine;

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F 000	Continued From page 2 W/C (w/c)- wheel chair; QS- every shift.	F 000		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident	F 622		7/20/18

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F 622	Continued From page 3 exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident.	F 622		

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F 622	Continued From page 4 (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review and other documentation as indicated, it was determined that the facility failed to ensure that one (R1) out of 3 residents was transferred in a manner that provided an effective transition of care. R1 was transferred from facility (F#1) to another facility (F#2) on 6/29/18. F#1 failed to have a transfer/discharge policy, to provide report to F#2 on R1's status prior to transfer, there was no physician order to transfer R1, and there was a lack of evidence that all pertinent paperwork was sent to F#2. All references to C#'s are staff at the receiving facility (F#2). Findings include: Review of R1's clinical record revealed the following: R1 was admitted to F#1 on 5/24/18 for short-term rehabilitation following a hospitalization. Review of a progress note written by E6 (NP) on 6/25/18, stated, " ...Anticipatory discharge from rehab (rehabilitation) services 6/28/18....". Review of the progress notes, dated 6/29/18, the day R1 was transferred to F#2, lacked evidence	F 622	Disclaimer Statement: Preparation and/or execution of this plan of correction (POC) does not constitute admission of or agreement to the facts and deficiencies alleged or conclusions set forth in the statement of deficiencies, and the facility disputes and denies any alleged deficiency or violation. Furthermore, no actions taken or to be taken pursuant to this POC are an admission that additional steps should have or could have been taken to prevent any alleged deficiency. The POC is prepared and/or executed solely because it is required by the provision of both Federal and State laws. A. R1 was transferred to another long-term care (LTC) facility and no longer resides in the facility. B. All residents transferred to another LTC facility have the potential to be affected. C. A procedure and practice has been formalized with regard to resident discharge to other LTC facilities. Specifically, a nursing discharge note regarding resident status will be written	

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F 622	Continued From page 5 of a nurse's note, including documentation of respiratory status and evidence that report was called to F#2. Review of physician orders revealed the lack of a physician order to transfer R1. 7/11/18 3:17 PM- E2 (DON) was asked for a copy of the transfer information provided to F#2. E2 stated there was no form, however, "the nurse calls report and sends hardcopy papers over that the facility needs, like care plans, meds (medications), etc.". E2 confirmed that a physician order was not written to transfer R1 and that a nurse's note should have been written, including what time R1 left. 7/12/18 12:39 PM- E4 (agency nurse, LPN) was assigned to R1 on 6/29/18. E4 was asked via telephone if he did R1's transfer and E4 stated, "No, I've never discharged anyone." 7/12/18 approximately 12:50 PM- E3 (LPN/UM) was asked if she did R1's transfer on 6/29/18 and E3 stated that she did not. When asked what her expectations were when a resident was transferred, E3 stated, " ...to call report (to the receiving facility), and send copies of notes." 7/12/18 2:21 PM- E5 (SS) was asked if she sent any paperwork to F#2. E5 stated that she faxed a copy of the face sheet, medications, and progress notes about a week before R1 left; when a decision was made by C1 (ED) to accept R1. 7/12/18 4:20 PM- During an interview with E5, she provided a copy of R1's Medication Review Report (summary of physician's orders) that was faxed from F#2's medical records department on	F 622	immediately prior to discharge which shall include condition of resident at time of discharge based upon assessment. Attempt to telephonically report current resident status will be made. If a resident requires supplemental oxygen during transport the cylinder will be confirmed to be full before discharge, and such confirmation will be documented on the transfer form. All transfer documentation, including the items referenced at ¿483.15(c)(2)(iii) will be preserved with appropriate time stamps to validate electronic delivery to and acceptance of receiving facility prior to resident discharge. A "hard copy" of this information will accompany the resident and will be hand delivered to a representative of the receiving facility. Brandywine will attempt to have said documentation signed for as proof of receipt by receiving facility and will document refusal of signature, should it occur. All licensed staff members responsible to discharge residents to a LTC facility and social service personnel have been in-serviced regarding the procedure and practice. D. All inter-facility (LTC to LTC) transfers will be reviewed by the DON/designee to ensure adherence to the procedure and appropriate transition of care until 100% compliance is achieved for three consecutive transfers to another LTC. Results will be reported quarterly through the facility QAPI process.	

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F 622	Continued From page 6 7/12/18 at 3:11 PM per request by E5 (E5 had previously faxed the report to F#2 on a different date). This was the only evidence of paperwork sent from F#1 to F#2. 7/13/18 1:05 PM- E3 was asked what the 6/28/18 date and time meant on R1's Medication Review Report. E3 stated that it was the date and time she printed the document. E3 was unable to provide a fax confirmation of when the Medication Review Report was sent to F#2. 7/13/18 12:55 PM- E2 confirmed that the facility does not have a transfer policy. An investigator from the Division of Health Care Quality (state) did interviews of key staff at F#2, obtained written statements and supplied copies of email correspondence to the surveyor. Documentation from F#2 revealed: 7/13/18 10:47 AM- C4 (RN) stated during an interview that the only documentation that came from F#1 was on 6/28/18 (the Medication Review Report) and the family gave them some paperwork from F#1 that was unclear. An undated written statement by C4 stated that she attempted to call F#1 for report, that the "fax number was given to the nurse and she stated that she will fax the report/paper work (sic) ... called facility another time reminding them that I am still waiting for the paper work ... we did not have any report ...". F#1 failed to have a transfer/discharge policy, provide report to F#2 on R1's status prior to transfer, failed to ensure a physician's order was written to transfer R1, and there was lack of	F 622		

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F 622	Continued From page 7 evidence that all pertinent paperwork was sent to F#2 to ensure an effective transition of care.	F 622		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other documentation as indicated, it was determined that the facility failed to ensure that one (R1) out of 3 residents received treatment and care in accordance with professional standards of practice, the comprehensive person centered care plan and the comprehensive assessment to meet their needs. R1 was transferred from this facility (F#1) to another nursing home (F#2) on 6/29/18 without ensuring that R1's oxygen tank had enough oxygen to get him safely to F#2 and without calling report to F#2. Consequently, R1's portable oxygen tank was empty upon arrival to F#2 (R1 required oxygen continuously) resulting in hypoxia (a deficiency of oxygen reaching the tissues of the body). Additionally, due to lack of a telephone report, F#2's staff were uncertain of R1's usual or prior baseline level of orientation (awareness of person, place and time) and pulse oximetry (pulse ox- a non-invasive test used to measure oxygen levels in the blood). R1 was pale upon	F 684	A. R1 was transferred to another long-term care (LTC) facility and no longer resides in the facility. B. All residents transferred to another LTC facility have the potential to be affected. C. A procedure and practice has been formalized with regard to resident discharge to other LTC facilities. Specifically, a nursing discharge note regarding resident status will be written immediately prior to discharge which shall include condition of resident at time of discharge based upon assessment. Attempt to telephonically report current resident status will be made. If a resident requires supplemental oxygen during transport the cylinder will be confirmed to be full before discharge, and such confirmation will be documented on the transfer form. All transfer documentation, including the items referenced at ¿483.15(c)(2)(iii) will be preserved with	7/20/18

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F 684	Continued From page 8 arrival to F#2, was oriented to person only, had a pulse ox of 79% (R1 had a physician order to maintain his pulse ox > 92%), and had abnormal lung sounds. R1 was subsequently sent to the hospital via 911 approximately 2 hours and 15 minutes after arrival to F#2. Findings include: Review of R1's clinical record revealed the following: R1 was admitted to the facility (F#!) on 5/24/18 for short term rehabilitation after being hospitalized. A hospital progress note, dated 5/23/18, stated that R1 was admitted to the hospital for a change in mental status due to a urinary tract infection, cellulitis of the right leg and pneumonia. Additionally, R1 had a history of dementia. R1's physician orders, dated 5/24/18, included oxygen at 3L/min. (liters per minute) via nasal cannula to keep pulse ox > 92% and check pulse ox every shift. R1's care plan, developed on 5/25/18 and updated on 6/1/18, for potential for alteration in cardiac/ or respiratory status stated that R1 was on oxygen on admission. Interventions included: allow extra time with activities of daily living (dressing and toileting, for example) to avoid SOB (shortness of breath), assess lung sounds as applicable, monitor vital signs and pulse ox as applicable, oxygen as applicable, and respiratory treatments as ordered. Review of R1's 5/31/18 admission/5 day, 6/7/18 Medicare 14 day and 6/21/18 Medicare 30 day MDS assessments, R1 used oxygen in the facility. The 6/21/18 MDS coded R1 as being	F 684	appropriate time stamps to validate electronic delivery to and acceptance of receiving facility prior to resident discharge. A "hard copy" of this information will accompany the resident and will be hand delivered to a representative of the receiving facility. Brandywine will attempt to have said documentation signed for as proof of receipt by receiving facility and will document refusal of signature, should it occur. All licensed staff members responsible to discharge residents to a LTC facility and social service personnel have been in-serviced regarding the procedure and practice. D. All inter-facility (LTC to LTC) transfers will be reviewed by the DON/designee to ensure adherence to the procedure and appropriate transition of care until 100% compliance is achieved for three consecutive transfers to another LTC. Results will be reported quarterly through the facility QAPI process.	

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F 684	Continued From page 9	F 684		

independent to make reasonable and consistent decisions.

6/25/18- 4 days prior to transfer to F#2, the last follow-up medical visit was done by E6 (NP). E6 stated, "...Anticipatory discharge from rehab (rehabilitation) services 6/28/2018 doing well overall supervision to standby assist with transfers able to bathe herself (sic) ambulates 25-50 feet with walker and supervision DOE (dyspnea on exertion- difficulty breathing when moving around) baseline remains on O2 (oxygen)... Lungs- clear...".

Review of nursing progress notes revealed:

6/26/18- R1's pulse ox's (ordered to be done every shift; all were done while on oxygen) were between 96-97% and temperatures (temps; normal range is 97.0- 99.0 degrees) was 98.1 degrees. Lungs clear.

6/27/18- pulse ox's were 95- 97% and temps. were 98.4 and 98.7 degrees. Respirations even and unlabored with no SOB or signs/symptoms of distress.

6/28/18- pulse ox's were 95-97% and temps. between 97.6- 98.3 degrees. Lungs clear and respirations non-labored.

6/29/18-

2:18 AM- pulse ox 92% and temp. 98.4 degrees. Lungs clear and respirations non-labored.

11:40 AM- there was no nurse's note written, however, pulse ox was 92% and temp. 97.8 degrees. Additionally, pulse was 68 (normal

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F 684	Continued From page 10	F 684		

range 60-100 beats per minute) and respiratory rate was 18 (normal range 12-20 breaths per minute).

6/29/18 2:20 PM by E5 (SS)- "resident transferred to (F#2) today for LTC (long term care)."

Interviews from F#1 revealed:

7/11/18 3:17 PM- E2 (DON) confirmed that a nurse's note should have been written when R1 was transferred to F#2 on 6/29/18, including what time R1 left.

A few minutes later, the surveyor was advised by E2 that there was video footage of R1 leaving the facility in E1's (NHA) office. The surveyor viewed the video footage of 6/29/18 and timed 11:52 AM of R1 being pushed in a wheel chair (w/c) down the hall and through the front door by C6 (driver of F#2). R1 was sitting upright in the w/c and had a nasal cannula in place for the oxygen and a small, portable oxygen tank was on the back of the w/c. . E1 and E2 were present while the surveyor watched the video footage and they gave details as needed like who was pushing R1 down the hall. E2 confirmed it was F#1's oxygen tank on the back of the w/c.

7/12/18 9:45 AM- E2 provided requested information for the nurse assigned to R1 on 6/29/18. E2 stated it was an agency nurse (a nurse provided by a contracted nursing agency).

7/12/18 12:39 AM- E4 (agency nurse, LPN) returned the surveyor's call. E4 explained that he worked in the F and G wing (Greenbank- where R1 resided) on day shift on 6/28/18 for the first time and that 6/29/18 was only his second time in

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F 684	Continued From page 11	F 684		

the facility. Surveyor asked if he did the transfer for R1 and he stated, "No, I've never discharged anyone." E4 further denied recalling if he checked R1's oxygen tank and stated that he really did not remember the resident. E4 stated to check with E3 (LPN/UM), that maybe she discharged R1.

7/12/18 approximately 12:50 PM- E3 (LPN/UM) stated that she's been the UM of the Greenbank unit since December 2017. E3 recalled R1 and stated that she did not do his transfer. E3 stated that R1 was transferred on a Friday and stated, "it was very chaotic." E3 stated that she was gone from the unit and when she returned, "he was gone." E3 stated that E4 (agency nurse) did the 11:40 AM vital signs and gave R1 medications on 6/29/18. She confirmed that E4 was very new to the facility. When asked what her expectations were when a resident was transferred, E3 stated, "an assessment, vital signs, to call report (to the receiving facility), and send copies of notes." E3 stated that E5 (SS) worked on the discharge.

7/12/18 2:21 PM- E5 (SS) stated that she began working in the facility a little over 2 months ago. When asked what she recalled about R1's transfer, E5 stated that R1's family decided to move him to F#2 for long term care because it was near his family. E5 stated that she dealt with C1 (ED of the receiving facility) for the transfer and C1 made the decision for F#2's driver (C4) to transport R1. E5 stated that R1 was going to be transferred in the AM of 6/28/18, but C1 changed it to 6/29/18. When asked if she knew what nurse did the discharge, E5 stated she did not know. When asked if any paperwork was sent by her, E5 stated that she faxed a copy of the face sheet, medications, and progress notes about a week before R1 left; when the decision was made by

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	085004	A. BUILDING _____ B. WING _____	C 07/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDYWINE NURSING & REHABILITATION CENTER	505 GREENBANK ROAD WILMINGTON, DE 19808

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F 684	Continued From page 12 C1 to accept R1. 7/12/18 4:10 PM- E2 (DON) stated that E5 (SS) just received a call from C1 (executive director at F#2) and he'd like the surveyor to speak with E5. While still speaking with E2, the surveyor discussed the interviews with E4 (agency nurse, LPN) and E3 (LPN/UM) in which both stated they did not transfer R1 on 6/29/18. Additionally, there was no evidence that anyone called report to a nurse at F#2 and that R1's oxygen tank was checked prior to his leaving to ensure there was a sufficient amount of oxygen to get R1 to the next facility. E2 confirmed this "might have fallen between the cracks" and he stated that the facility was already working on a plan of correction ...". 7/12/18 4:20 PM- E5 (SS) stated that C1 (ED at F#2) called her and asked for clarification of how R1 was transported to them. E5 stated that she told C1 that they (F#2) used their own transportation. E5 stated that C1 told her that she did not know R1 was on oxygen and that R1 should have been sent by ambulance. E5 provided a copy of R1's Medication Review Report (summary of physician orders) that she stated was faxed from medical records staff at F#1. The fax was dated 7/12/18 and timed 3:11 PM. On page 4 of 6, there was a physician order for "Oxygen @ (at) 3 L/min via nasal cannula to keep SPO (same as pulse ox) > 92%. Check sat (same as pulse ox) O2 (oxygen) level QS (every shift)." E5 provided a fax activity log with highlighting on 6/22/18 showing 27 pages that were sent and 6/27/18 showing 6 pages were sent to the same fax number which E5 stated were at F#2. E5 explained that the 6/22/18 fax she sent included	F 684		

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F 684	Continued From page 13	F 684		

R1's face sheet, medications, and progress notes (as stated in 2:21 PM interview). E5 stated the 6/27/18 fax was the Medication Review Report sent by E3.

7/13/18 12:55 PM- E2 (DON) confirmed that the facility does not have a transfer policy.

7/13/18 1:00 PM- Surveyor asked E5 (SS) for clarification of the Fax Activity Log with 6 page Medication Review Report sent by E3 (LPN/UM) to F#2 on 6/27/18 per interview with E5 on 7/12/18 at 4:20 PM. Surveyor advised the Medication Review Report was dated 6/28/18 and timed 2:39 PM, not 6/27/18. E5 stated that she must not have been clear, the faxes from her included the 6 pages sent on 6/27/18. E5 stated that E3's papers were probably sent from a different fax machine.

7/13/18 1:05 PM- E3 was asked what the 6/28/18 date and time meant on R1's Medication Review Report. E3 stated it was the date and time that she printed the document. Requested fax confirmation to show when the Medication Review Report was sent to F#2. E3 stated that she was only able to go back one week, so she was unable to provide it.

An investigator from the Division of Health Care Quality (state) did interviews of key staff at F#2, obtained written statements and supplied copies of email correspondence to the surveyor.

Documentation from the receiving facility (F#2) revealed the following:

7/12/18 4:12 PM- email from C1 (ED) stated, "(F#1) wanted to transfer (name of resident) in

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their van at 8 am on 6/29 to (F#2). We felt that was too early for him, so we agreed to pick him up 11am in our van... (resident) was not ready. They (F#1) had to clean him up and pack his clothes... they put him in a wheelchair with mini oxygen tank on the back and he left in F#2's van around 11: 45 pm (sic)... He arrived to our 3rd floor HC (healthcare) about 12:15 pm ...". The driving distance from F#1 to F#2, depending on the route taken, was between 8.6- 9.2 miles.

7/13/18 10:39 AM- interview with C3 (ADON) confirmed that C4 (RN) assessed R1; C3 did not observe R1.

7/13/18 10:41 AM- interview with C2 (DON) stated that C4 and C5 (LPN) were the nurses involved with R1 prior to his being sent to the hospital. C2 stated that R1 was only at the facility briefly and he stated that he only knew what he heard. C2 stated that the facility does not have a transportation policy.

7/13/18 10:47 AM- interview with C4 (RN) confirmed that C5 (LPN) was the first person to see R1. C5 then went and found C4. C4 stated that she assessed R1. C4 stated the only documentation that came from F#1 arrived the day before (6/28/18- the Medication Review Report) and the family gave them some paperwork from F#1.

An undated written statement was received from C4 on 7/13/18. C4 stated that she attempted to call the facility for report, that the "fax number was given to the nurse and she stated that she will fax the report/paper work...called facility another time reminding them that I am still waiting for the paper work... received by the charge/med

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F 684	Continued From page 15 (medication) nurse (C5). Vital signs were obtained by the med nurse and she told me that the new resident seems to be in respiratory distress because his oxygen (pulse ox) was 79%. Med nurse stated that the portable (oxygen) tank was empty when resident was received in the facility... alert to self, very confused and not able to complete a sentence... we did not have any report. Family stated that resident is usually very alert and oriented... Family was made aware that according to this nurse assessment patient seemed to be very sick and according to their information it seems that there is a change in mental status... lungs are not clear and we will need STAT chest xray to R/O (rule out) PNA (pneumonia). This nurse told the family that I was not comfortable admitting the resident to the facility whom according to my nursing judgement I knew he needed more medical attention than we cannot (sic) provide. The family agreed to send... to Emergency room... 911 was called by this nurse and resident was transported to the hospital...". 7/13/18 10:59 AM- interview with C5 (LPN) stated that R1 arrived about 12:30 PM on 6/29/18. C5 checked R1's vital signs and his pulse ox was 79% (physician's order was to maintain pulse ox > 92%). She stated that R1 arrived with a nasal cannula on and the portable oxygen tank he came with was empty. C5 stated that she ran and got an oxygen concentrator and applied oxygen at 2 L/min. Initially the pulse ox remained at 79%, then it came up to 89%. C5 increased the oxygen to 3 L/min. and then to 4 L/min. C5 stated she didn't know what R1's diet was, they were waiting for orders and C4 (RN) was calling F#1. C5 stated that R1 told her his name and what he liked to be called. C5 stated that she didn't know	F 684		

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what R1's baseline was and if this was normal; he had a rash on his palms and the backs of his hands. When she listened to R1's lungs she heard crackles and asked (family?) if he had pneumonia. One of the daughters stated that the hand rash wasn't there the day before. C5 stated that R1 wasn't struggling to breathe, but he appeared tired. She offered food and R1 declined, but he drank a few sips of coffee. C5 stated that she talked to R1's family and explained that she doesn't know R1, but he didn't look right. She stated the family took a little while to decide before sending R1 to the hospital. Additionally, R1 wanted to use the urinal, but he was unable to stand. C5 stated that R1 never complained of pain or of feeling sick.

A progress note, written by C5 (LPN) and dated/timed 6/29/18 at 2 PM stated that R1 arrived with the facility's driver about 12:10 PM. Skin was slightly pale. His vital signs were T 97.2-102- 20- 126/70 and pulse ox 79%. R1's oxygen was increased to 4 L/min. to maintain his pulse ox > 92%. Crackles were heard in the lower lobes of his lungs and he did not have a cough.

7/13/18 11:10 AM- interview with C1 (ED) stated that E5 (SS from F#1) called and they were going to send R1 at 8 AM. C1 stated that she's not used to doing 8 AM transports and F#2 doesn't usually transport residents, but she arranged for them (F#2) to transport R1 at 11 AM. C1 stated that she was unaware R1 was on oxygen and was not told that. C1 stated F#2's driver (C6) went to pick up R1 after getting clarification from their corporate office that F#2 could transport residents.

7/13/18 11:20 AM- interview with C6 (driver)

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F 684	Continued From page 17 stated that he arrived at F#1 at 11:15 AM and a daughter was there waiting. C6 stated that F#1 staff had "no idea that R1 was going anywhere"; they had to prepare R1 to leave by giving him a shower and taking him to the bathroom, which took about 45 minutes. C6 stated when they were leaving, R1 got his medications. C6 stated he got back to F#2 about 12:15 PM. When asked how R1 was during the transport, C6 stated he was "bright and alert." Review of the BLS (basic life support- less critical than EMS or emergency life support) Prehospital Care Report, dated 6/29/18, stated that dispatch was notified at 2:03 PM and the BLS unit was notified at 2:07 PM. BLS arrived at F#2 at 2:13 PM and to R1 at 2:15 PM. R1's vital signs at 2:15 PM were 82 (pulse), 142/96 (BP) and a GCS of 15 (Glasgow Coma Scale [GCS]- a summation of scores for eye, verbal and motor responses. The minimum score is 3 which indicates a deep coma or a brain dead state. The maximum is 15, which indicates a fully awake patient). BLS' narrative stated, " ... Upon arrival (at F#2) family members stated pt (patient) was not acting right. Pt was on 4L of O2 via (by) nasal cannula ...rash on hands from unknown cause ... vital (signs) were obtained and stable and was put on 6L of O2 via nasal cannula ...alert and oriented on way to ... hospital ... complained of no pain ...". The assessment by BLS stated, " ...field impression ... no apparent illness or injury. Treatment began utilizing the following protocols: Altered Mental Status, General Patient Care." R1's pulse ox at 2:18 was 99% with a low concentration O2 of 1-6 LPM (liters per minute). The report did not include what R1's respiratory rate was and a lung assessment. The only medical treatment by BLS was monitoring R1's	F 684		

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F 684	Continued From page 18 vital signs, GCS, and administering oxygen. BLS departed F#2 at 2:26 PM and arrived at the hospital at 2:49 PM. Hospital records were reviewed for the 6/29/18 admission. R1's initial vital signs at 3:10 PM in the ER were T. 99.2- 92- 16- 137/63 and pulse ox 99%. A nurses note timed 4:01 PM stated that R1's oxygen was reduced to 4 L/min. with a pulse ox of 94%. (from 6 L/min...). Vital signs at 7:55 PM were T 97.0- 95- 18- 131/77 and pulse ox 97%. R1 was transferred to ICU at 9:25 PM on 6/29/18 to ICU without incident. The ER physician's diagnoses included PNA in both lungs, acute renal failure and non-specific rash. R1 expired on 7/4/18. A copy of the death certificate was obtained. The cause of death was pneumonia with no secondary causes listed. F#1 failed to ensure that R 1 was transferred to F#2 in a manner that provided a safe and effective transition of care. Specifically, F#1 failed to: Ensure that R1 was ready for the transport- - R1 had to be showered, toileted, and medicated after F#1's van arrived to collect the resident. Assess the resident prior to transfer- - No documentation of mental status giving F#2 no baseline to guide them in their assessment. - No documentation of a prominent rash on R1's hands, noted upon arrival to F#2. - No documentation of rales, noted upon arrival at F#2.	F 684		

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F 684	Continued From page 19 Check R1's oxygen tank prior to leaving F#1 to ensure that there was enough oxygen in the tank for transfer- - R1 arrived at F#2 with an empty tank of oxygen (R1 required continuous use of oxygen). - R1 was hypoxic with a pulse ox of 79% (pulse ox was to be maintained > 92%). Call report to the receiving facility- - R1 was sent to the hospital approximately 2 hours and 15 minutes after arrival to F#2 due to a change in condition. R 1 was subsequently hospitalized.	F 684		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Brandywine Nursing & Rehab Center **DATE SURVEY COMPLETED: July 19, 2018**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced complaint survey was conducted at this facility from July 10, 2018 through July 19, 2018. The deficiencies contained in this report are based on interviews, record reviews, and review of other documentation as indicated. The survey sample included three (3) closed records.	Disclaimer Statement: Preparation and/or execution of this plan of correction (POC) does not constitute admission of or agreement to the facts and deficiencies alleged or conclusions set forth in the statement of deficiencies, and the facility disputes and denies any alleged deficiency or violation. Furthermore, no actions taken or to be taken pursuant to this POC are an admission that additional steps should have or could have been taken to prevent any alleged deficiency. The POC is prepared and/or executed solely because it is required by the provision of both Federal and State laws.	
3310	**Regulations for Skilled and Intermediate Care Facilities**		
3310.1.0	**Scope**	Please refer to the electronic POC on the 2567-L survey report submitted via the Aspen web portal for the survey ending 7/19/18 for F622 and F684.	07/20/2018
3310.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** Cross Refer to the CMS 2567-L survey completed July 19, 2018: F622 and F684.		

Provider's Signature _____ Title ADMINISTRATOR Date 8/14/2018